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ABSTRACT

This paper presents data on a follow-up study of a project in the 1960's: a classroom assessment and intervention program directed at mental health for all the first grade classrooms of Woodlawn, a black poor community on Chicago's south side. Now, ten years later, the mental health of these adolescents as well as the mental health, structure, and process of the family are being studied. The general research objective is to learn what early and concurrent factors predict good versus poor functioning at adolescence. The study reported here focuses primarily on the "How I Feel" instrument constructed to measure self-reported psychological well-being in adolescence. To circumvent the generally poor reading skills of the population, the test items are presented on a tape accompanied by a single answer booklet in which answers are reported. The tapes were produced by a black actor. Items were developed for the usual clinical components of psychopathology: anxiety, depression, anger and aggression, bizarre-peculiar-paranoia, obsessions, and compulsions, fears and phobias, mania and grandiosity, plus a global psychopathology construct. Results of the various statistical analyses and reliability and validity data are included. The results show great potential for affective measurement in school settings. (RC)

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The Measurement of Psychological Well-Being: A Multi-Media Approach

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To properly frame the study reported here, we first describe the background of the larger longitudinal research project. We then describe the pilot study, which was partly conducted for the purpose of testing our measure of psychological well-being. Finally we present the results of our reliability and validity studies.

Background of this Research

In the early 1960's the originators of this project met with community leaders of Woodlawn, a black poor community on Chicago's south side, to discuss the possibility of providing a mental health program for the community. It was the desire of this community's residents that the focus of any mental health intervention be on the community's children. Therefore, a classroom assessment and intervention program directed at mental health was developed for all the first grade classrooms in this entire community. Four successive cohorts of first graders in Woodlawn experienced the mental health intervention, a sort of group therapy, and the results of this intervention in relation to achievement and other measures of mental health have been reported in a recent book, Mental Health and Going to School (Kellam, et al, 1975).

Mental health has been broadly conceived in this study to consist of two conceptually independent dimensions. One dimension is the primary component of the traditional psychiatric view of mental health, which we call psychological well-being. Psychological well-being considers mental health from the individual perspective measured by self-reports or on the basis of symptoms or other psychiatric indicators commonly assessed by clinicians. The second dimension of mental health we call social adaptational status. This dimension consists of a societal view of the adequacy of the role functioning of the individual and is naturally assessed throughout life by so called natural raters. These natural raters periodically assess the adequacy of the individual's role functioning in the various social fields. For example, parents assess the child's functioning in the family, teachers assess functioning in the school (e.g., through grades or achievement tests) and peers assess the child's functioning in the peer group.

The Follow-up Study

We are now following up one of these cohorts of children 10 years later. About 85% of these 1250 former Woodlawn first graders still live in Chicago, but only 30% remain in the Woodlawn community. We have reinterviewed 75% of the Chicago teenagers' mothers, and we are currently completing the reassessment of these youth. We had hoped to have these data to report here, but as frequently happens in such a large scale project, we are behind schedule.

In our follow-up study of the former Woodlawn teenagers, we are studying the mental health of the teenagers as well as the mental health, structure, and process of the family. The general research objective is to learn what early and concurrent factors predict good versus poor functioning at adolescence. Among the specific measures of the teenager's social adaptational status are school achievement, delinquency, drug abuse, peer group relationships, and family relationships.

Psychological well-being is primarily measured by the instrument reported here, the How I Feel. In addition a random half of these teenagers will be assessed by clinicians in a semi-structured clinical interview.

The Pilot Study

Before proceeding with our follow-up study, we needed to resolve several research questions and try out various assessment procedures. The pilot study was conducted in 1975 in two Chicago communities with half of the assessments done in schools and the other half in community settings.[1] We found no differences with any of our constructs between these populations or settings. In addition, we assessed a clinical sample of teenagers.

In this presentation we will be focusing on the instrument constructed to measure self-reported psychological well-being in the adolescent years. We were constrained in our instrument development by two considerations: (1) the instrument needed to preserve the constructs measured in first and third grades and yet be appropriately valid for teenagers and (2) in particular, the instrument needed to be valid for our particular population of teenagers. A consideration to achieve the validity mentioned in the second instance, that is, validity for our particular population, entailed designing an instrument which overcame the problems associated with low reading skills. Some of the teenagers in our population, as among teenagers in Chicago generally, have very poor reading skills. In earlier phases of our pilot study we learned that requiring the teenagers themselves to read the questions greatly prolonged the assessment time and created management problems during the assessment session. Furthermore, even though all teenagers eventually completed their assessments, we felt that some

[1]We gratefully acknowledge the collaboration in the pilot study of Jeannette Branch, Director of the Southside Youth Program; Mrs. Branch directs the treatment program related to this research and supervises the assessment process. We are also grateful to Margaret Ensminger, who is an Associate Director of the Study Center in charge of field assessments.

of the poor readers simply checked responses in order to appear finished rather than to subject themselves to the stares and comments from their classmates who had already completed the assessment.

Therefore, to circumvent the problems associated with reading we developed a multi-media assessment method. Our method was adapted from that used by R. Darrell Bock of the University of Chicago, in his testing for spatial ability and other skills. We present the items on a tape accompanied by a simple answer booklet in which answers are recorded. The tapes were produced for us by a black actor. For the instrument presented here, we also show the items on slides, though this presentation is redundant and not central to the assessment.

Our experiences in the prepilot stage of our studies validated our use of this tape technique. We had the instrument reported here on tape and slides with a second questionnaire still requiring reading. When asked at the end which format they preferred, all students preferred the tape format to the reading with those who took the longest to read the second questionnaire expressing the strongest preference for the tape presentation.

I wish to make one further point about our assessment process because it was new to me and I suspect new to many educational researchers. My colleagues coming from the mental health fields impressed upon me the great importance of achieving the trust and the comfort of the teenagers before proceeding with the assessment. When attempting to obtain highly personal and potentially embarrassing or even legally incriminating information, it is essential that the assessment process begin with a period of engagement with the youth. Our experience demonstrates that when engagement is successfully achieved, the self-reports are more valid and more complete than when we do not provoke the teenagers to express their fears and distrust. There seems to be a relationship between silence on

the part of the teenagers before we begin the assessments and silence in the form of missing data on their assessments.

The HOW I FEEL [1]

The How I Feel, measures the lack as well as the presence of psychological well-being. Psychopathology measures lack of psychological well-being. We developed items for the usual clinical components of psychopathology: anxiety, depression, anger and aggression, bizarre-peculiar, bizarre-paranoia, obsessions and compulsions, fears and phobias, mania and grandiosity, plus a global psychopathology construct.

The name psychological well-being connotes positive functioning as well. We considered three major areas of positive self-view: self-esteem, body concept, and self-evaluation of social adaptational status (SAS). (Recall that SAS is the second major dimension of mental health in our framework.)

We used Freud's (1937) concepts of lieben and arbieten (love and work) as the basis of our conceptualization of self-esteem. We added play, hope, and a global scale to these two constructs to round out our view of self-esteem.

Two scales measure body concept: global body image (taken from the Offer Self-Image Questionnaire) and satisfaction with body parts (Bohrnstedt, 1974).

The final positive construct consists of the self-evaluation of and satisfaction with social adaptational status in four social fields: the classroom, the family, the peer group and the opposite sex.

All items in the How I Feel are statements phrased in the first person. The response scale is a 6-level scale ranging from "not at all" to "very, very much." Thus, we are asking the individual to make a subjective judgment about psychological well-being. Each individual establishes his or her own anchor points and is therefore making a implicit relative statement about self.

[1]The authors gratefully acknowledge the collaboration of Dennis McCaughan and especially Zanvel Klein in the development of the How I Feel.

Results

Turning now to the results of our pilot study, we first note in Table 1 that most of the positive constructs[1] center around 5 (6 is "very, very much") while the psychopathology constructs are in the 2 to 3 range (1 being "not at all"). The standard deviations of the positive constructs, except the body constructs, are also slightly lower than the psychopathology constructs, perhaps because of a ceiling effect with the former. Most of the constructs, except for self-esteem, were fairly reliably measured. Those with low α-coefficients were either dropped from the instrument for the follow-up or, if the construct was considered conceptually important, new items were added and old ones improved. All constructs have 7 items in the follow-up How I Feel.

Validity

The highest mean psychopathology rating was for obsessions and compulsions. The next highest rating is mania/grandiosity though we must note here that some items in this construct we clearly considered positive while others were more like psychopathology items for our teenagers. Paranoia seems to be fairly high, though we have little basis for comparison. Depression, a more severe problem in other studies of adolescents (Masterson, 1967; Offer, 1969), was the least severe in these self-reports. Work and body satisfaction were the lowest mean ratings among the positive constructs, though these are both about 1 point higher that the highest mean psychopathology rating. Thus, our sample could be characterized in terms of our constructs as fairly positive in self-view with some amount of obsessive/compulsiveness and paranoia.

Sex-related differences are footnoted in Table 1. Girls in our sample report themselves as more psychopathologic in 5 out of 9 psychopathology scales

[1]Construct scores consist of each individual's mean score for all the items in the construct. Latent trait analysis of construct items are currently underway; these scores will be used in the future.

and also have a lower body image.

The intercorrelations among all the psychopathology constructs,as well as among all the self-esteem constructs,are significantly different from zero but there are relatively few significant correlations between the psychopathology and self-esteem constructs. In part this is due to the low reliabilities of the self-esteem constructs. Global self-esteem does relate in a predictably negative fashion to most of the psychopathology constructs. In particular, we would expect higher correlations between global self-esteem and anxiety and depression. Crandall (1975) reports that anxiety is generally correlated -.6 with self-esteem. Nevertheless, all of the correlations which exist are in the predicted direction.

Table 3 shows results of factor analyses of various sets of How I Feel items. We may immediately note that the number of principal components is always greater than the number of conceptually-based constructs. The items from our 9 psychopathology constructs form 20 independent components. The items from our 5 self-esteem constructs form 10 independent components. Part of this "splitting off" is surely due to unreliability and other sources of measurement error.

The content of components, both unrotated and rotated, suggests that there is substantial mixing of items from various constructs when examined empirically. The mixing that exists is logical, however. For example, depression and global psychopathology items showed substantial mixing in the components. These construct scores were also highly intercorrelated. Furthermore, it makes sense that a teenager experiencing depression would feel bad generally. Some sets of items do form fairly descrete constructs; for example, satisfaction with body parts, hope and anger/aggression all form independent components similar to the conceptual constructs.

We examined the predictive validity of the How I Feel by comparing the results obtained with our "normal" pilot population with those obtained from a group of teenagers who either had been or were still in therapy. It should be noted that there is probably some real overlap in the psychological well-being of the teenagers in these two samples. There are surely some the "normal" teenagers with fairly serious problems at the same time that some of the teenagers included in the clinical population are now functioning fairly well. Nevertheless, in Table 4 we find differences in the means on all constructs in the predicted direction. That is, the clinical sample presents more psychopathology and lower self-esteem, body image, body satisfaction, and self-evaluation of social adaptational status than the normal group. These differences are significant for global psychopathology, anxiety, depression, mania/grandiosity and satisfaction with body parts.

Criterion-related validity was measured in the pilot study by comparing the How I Feel to the Coopersmith Self-Esteem Inventory and to the Offer Self-Image Questionnaire. Table 5 shows the correlations between the HIF and the Coopersmith. All of the significant correlations are in the prediceted direction and only 4 HIF constructs are not significantly related to self-esteem as measured by the Coopersmith.

Despite the fact that we obtained data on the Offer Self-Image Questionnaire from only 21 teenagers, we see many significant correlations between the Offer questionnaire and the How I Feel, all in the predicted direction (Table 6). In particular, negative emotional tone and psychopathology on the Offer are related to most of the How I Feel psychopathology constructs.

Thus, the How I Feel appears to be measuring areas similar to those of the

Coopersmith Self-Esteem Inventory and the Offer Self-Image Questionnaire. The unreliability of the self-esteem constructs in the HIF attenuates their correlations with other measures. The overall consistency of relationships, together with the conceptual validity of self-esteem led us to retain and improve these constructs in the follow-up instrument.

We also examined the relationships between the How I Feel constructs and the constructs measured by our second questionnaire, the What's Happening. The What's Happening was designed to tap important areas of family life, peer interactions and other constructs of societal importance. Most of the questions in the What's Happening ask for reports of behavior. Some of these constructs are very reliably measured and others are less reliable.

In Table 7, we may particularly note the negative correlations between psychopathology and satisfaction with family interaction, satisfaction with friends, high hopes and expectations regarding school, and internal locus of control. Psychopathology shows positive relationships to the expression of anger in the family, self-reported delinquency, and strength of attribution of causality.

Self-esteem in the How I Feel is related in a negative direction to the expression of anger and positively to closeness with adults in the family, respect for parents, strong identification with parents, satisfaction with friends, and high hopes and expectations regarding school. Self-evaluation of SAS is related to most of the What's Happening constructs, in the predicted direction.

Discussion and Conclusions

We felt that it was important to consider both psychopathology and positive

constructs in our measure of psychological well-being. The results just presented support this view; in many cases psychopathology has different relationships than self-esteem or other positive constructs to various criterion measures. We were not satisfied with the adequacy of all the constructs measured and we attempted to rectify these difficulties in our follow-up instrument. We are highly pleased with our assessment procedures themselves.

We have not yet addressed the issue of the relevance of psychological well-being tc school achievement and other measures of social adaptational status. Our earlier research (Kellam, et al, 1974) with first and third grade children suggested that poor psychological well-being was linked to prior school failure. Another kind of early stress, which we labelled "fateful events" (e.g., change of teacher or school in first grade), produced temporary set-backs in mental health which later became strengths, manifested by better achievement and psychological well-being. But personal failure (e.g., early school failure) tended to produce persistent downward trends in both achievement and psychological well-being, probably mutually reinforcing each other. Our prediction for our follow-up study is that those children who experienced early failure in school will, by age 16, be more likely to be delinquent, drug users, school dropouts, and suffer from various problems with psychological well-being. Preliminary data based on mother reports support this hypothesis. Poor first grade status in either dimension of mental health--social adaptational status or psychological well-being--predict poorer achievement, more delinquency, and lower mental mental health (SAS and PWB) ten years later. Those children who were both maladapting and symptomatic in first grade show an even greater likelihood of later delinquent behavior than those suffering from only one of the two.

What are the implications of these results for intervention? Is a sole

focus on achievement skills the appropriate way to ameliorate the range of problems apparently resulting from poor achievement? Or must an effective intervention focus on both aspects of functioning? We do not know the answer though we are studying the problem in a treatment study with the follow-up teenagers. We hypothesize that a dual focus on both achievement and psychological well-being will produce the best results. The psychopathology that frequently results from schoool failure is real and not transitory and, we speculate, cannot be ameliorated simply by correcting the learning deficiencies, especially when intervening as late as adolescence.

A more appropriate solution to the total problem may be that offered by the Mastery Learning approach forwarded by Bloom and his colleagues (Bloom 1974; Block, 1971). If failure is not experienced by most children, but rather successful learning is attained, many young people may not begin the downward cycle of poor psychological well-being and lower achievement. Preliminary evidence for this outcome is very encouraging.

We must also acknowledge that no program will eradicate mental illness. Some children will always suffer from psychopathology or poor self-esteem no matter how effectively we construct the school environment for optimal learning. And until we even begin to approach this happy state of affairs it is essential that we continue to assess psychological well-being so that we can properly evaluate our progress.

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TABLE 1

HIF Construct Means, Standard Deviations, and Reliabilities[1]

Construct	Mean[2] (Std. Dev.)	# Items	Reliability[3]
Psychopathology-Global	2.20 (1.13)	7	.78
Anxiety[4]	2.59 (0.92)	9	.75
Depression[4]	2.04 (0.96)	8	.77
Anger/Aggression[4]	2.69 (0.94)	9	.74
Bizarre-Peculiar	2.74 (1.04)	7	.66
Bizarre-Paranoid	2.97 (0.90)	8	.64
Obsessive/Compulsive[4]	3.72 (0.92)	7	.62
Fears/Phobias[4]	2.90 (1.02)	6	.54
Manic/Grandiose	3.46 (0.87)	6	.46
Self-Esteem Global	4.80 (0.85)	5	.49
Love	5.12 (0.61)	5	.37
Work	4.56 (0.79)	4	.38
Play	5.13 (0.71)	4	.33
Hope	5.13 (0.64)	5	.30
Body Image-Global[4]	5.00 (0.97)	5	.53
Satisfaction	4.63 (0.93)	10	.79
Self-Evaluation of SAS	4.80 (0.77)	8	.60

[1] $n = 61$

[2] The scale runs from 1 = not at all to 6 = very, very much

[3] Cronbach's α Coefficient

[4] These constructs show significant sex-related differences, all suggesting that girls feel worse about themselves than do boys.

TABLE 2

Correlations Among HIF Constructs[1]

	Psychopathology									Self-Esteem					Body		SAS
	Glo	Anx	Dep	Ang	Dec	Par	ObC	Fer	Man	Glo	Lov	Wor	Pla	Hop	Glo	Sat	SEv
Global Psycho																	
Anxiety	63																
Depression	78	72															
Anger/Aggress	45	57	51														
Biz-Peculiar	52	57	61	59													
Biz-Paranoid	52	53	53	62	64												
Obess/Compul	48	61	50	37	51	50											
Fear/Phobias	48	57	46	52	47	40	57										
Manic/Grand	21	34	22	24	32	37	45	21									
Global SE	-49	-28	-45		-22	-18											
Love				-20					20	39							
Work	-23								19	48	41						
Play	-18			-19						49	54	40					
Hope										36	43	23	35				
Global Body	-52	-47	-54	-42	-44	-35	-37	-35		52		21	19				
Body Satis		-22	-18	-18	-21					27		33		25	32		
Self-Eval SAS	-34	-33	-26	-35	-21	-37				47	26	48	52	20	27	22	

[1] n = 80, significant ($p < .05$, two tailed test) correlations are shown ($r \geq .18$)

TABLE 3

Principal Components of Sets of HIF Items[1]

Psychopathology and Self-Esteem Items (90)

Component	Eigenvalue	Cum Pct Var
1	18.05	20.1
2	6.32	27.1
3	3.67	31.2
4	3.44	35.0
5	2.92	38.2
6	2.69	41.2
7	2.63	44.1
8-13	2.50-2.03	59.3
14-18	1.95-1.59	69.0
19-27	1.47-1.01	81.3

Positive Items (46)

Component	Eigenvalue	Cum Pct Var
1	7.31	17.4
2	3.60	26.0
3	2.73	32.5
4-5	2.14-2.04	42.4
6-9	1.19-1.52	58.9
10-14	1.35-1.09	73.3

Psychopathology Items (67)

Component	Eigenvalue	Cum Pct Var
1	17.31	26.2
2	3.43	31.4
3	2.79	35.6
4	2.56	39.5
5-7	2.23-2.01	49.1
8-13	1.97-1.52	64.3
14-20	1.41-1.00	77.2

Self-Esteem Items (23)

Component	Eigenvalue	Cum Pct Var
1	4.81	20.9
2-4	1.81-1.70	44.0
5-10	1.43-1.01	74.8

[1] $n = 80$

TABLE 4

Comparison of Normal versus Clinical Samples on HIF

Construct	Normal[1] Mean (S.D.)	Clinical[2] Mean (S.D.)	Univ. Sig.
Global Psycho	2.20 (1.13)	2.87 (1.36)	*
Anxiety	2.59 (0.92)	3.42 (1.28)	**
Depression	2.04 (0.96)	2.84 (1.11)	**
Ang/Aggress	2.69 (0.94)	3.20 (1.31)	
Biz-Peculiar	2.74 (1.04)	3.22 (1.34)	
Biz-Paranoia	2.97 (0.90)	3.44 (1.46)	
Obses/Compul	3.72 (0.92)	4.01 (1.16)	
Fear/Phobia	2.90 (1.02)	3.21 (1.20)	
Manic/Grand	3.46 (0.87)	3.93 (0.98)	*
Global SE	4.80 (0.85)	4.44 (1.06)	
Love	5.12 (0.61)	5.00 (1.00)	
Work	4.56 (0.79)	4.45 (1.02)	
Play	5.13 (0.71)	5.05 (0.93)	
Hope	5.13 (0.64)	4.98 (0.95)	
Global Body	5.00 (0.97)	4.62 (0.89)	
Satis Body	4.63 (0.93)	4.14 (1.11)	*
Self Eval SAS	4.80 (0.77)	4.67 (1.02)	

[1] $n = 61$

[2] $n = 19$

[3] by t-test for comparison of means with unequal variances(Brownlee, 1965, 299)
* $p < .05$, ** $p < .01$

TABLE 5

Correlations between the HIF and Coopersmith Self-Esteem Inventory[1]

HIF Construct	r
Psychopathology-Global	-.63
Anxiety	-.43
Depression	-.49
Anger/Aggression	-.36
Bizarre-Peculiar	-.51
Bizarre-Paranoid	-.51
Obsessive/Compulsive	-.45
Fears/Phobias	-.31
Manic/Grandiose	
Self-Esteem-Global	.48
Love	
Work	.34
Play	
Hope	
Body- Global	.58
Satisfaction	.42
Self-Evaluation of SAS	.61

[1] n = 39, only significant ($p < .05$, two-tailed) correlations are shown ($r \geq .26$)

TABLE 6

Correlations between the HIF and Offer Self-Image Questionnaire

		Offer SIQ									
		Impulse Control	Emotional tone	Body & Self Img	Social Relnships	Morals	Sexual Attitudes	Family Relnships	Mastery	Voc/Ed. Goals	Psychopathology	Sup Adjustment
HIF	Global Psycho										44	
	Anxiety		-67			-46					50	
	Depression		-47				-42				62	
	Anger/Aggression		-54			-36					48	
	Biz-Peculiar						-42				58	-40
	Biz-Paranoid		-48		-52	-51	-38				32	
	Obesess/Compul		-36							37	47	
	Fears/Phobias		-60									
	Manic/Grand									45		
	Global SE	38		48		36				49		
	Love	46									-42	
	Work				38	42						
	Play						41					
	Hope											
	Global Body		45			59		44				
	Body Satis											
	Self-Eval SAS		37	44	37	47		74				

[1] $\underline{n}$ = 21, only significant ($p < .05$, two tailed) correlations are shown ($r \geq .36$)

[2] This has been reflected so that a high score means high psychopathology.

TABLE 7

Correlations between HIF and What's Happening[1]

		What's Happening																												
		Family										Peers			Society															
		Activ	#Adults	Satis	Confid	Expr Ang	Expr Aff	Closeness	Rules	Respect	Ident Par	Number	Satis	Leader	Sch Inv	Police	Delinq	Trig Use	Age Drug	Hope/Exp	I Loc Con	Attr Caus								
	Global Psycho			-29		34				-27	26		-24				21			-36	-30	22								
	Anxiety					35							-24			20	25			-20	-43	21								
	Depression		21			25							-22	-20					-20	-28	-43	22								
	Anger/Aggres			-31		27	-20						-23				22		-24	-22	-35									
	Biz-Peculiar			-23		31					20		-32	-29			31				-41									
	Biz-Paranoia			-28		26				-21			-32		21	29	41	23			-45	25								
	Obeses/Compul					22															-31	24								
	Fear/Phobia																					25								
HIF	Manic/Grand													23					-27	-30										
	Global Se				29	-35	26	20		45	47		33							39										
	Love			29		-24			-37	20			39							22										
	Work					-32				24	23		27		26					25		-25								
	Play		21	35				28	-30	39	36		23	35						28										
	Hope	24	24					27						33		-28	-31	-20	-20	21										
	Global Body				24	-34					25																			
	Body Satis						24									-25	-23			20										
	Self-Eval SAS	29	28	50	32	-45	35	24	-24	45	53		44		31	-29	-31													

[1] $n = 65$, only significant ($p \leq .05$, two-tailed) correlations are shown ($r \geq .20$)